



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-877-814-9709.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	For in-network and out-of network providers \$2,500 individual / \$5,000 family Doesn't apply to preventive care.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	For in-network and out-of-network providers \$4,000 individual / \$8,000 family	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network</u> of <u>providers</u> ?	Yes. For a list of <u>in-network providers</u> , see www.anthem.com or call 1-877-814-9709. This plan uses the Blue Access PPO.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about <u>excluded services</u> .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	_____none_____
	Specialist visit	20% coinsurance	40% coinsurance	_____none_____
	Other practitioner office visit	20% coinsurance	40% coinsurance	_____none_____
	Preventive care/screening/immunization	No charge	40% coinsurance	Not subject to deductible.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	_____none_____
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	_____none_____

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State of Indiana – Local Units of Gov't: CDHP Plan 1

Coverage Period: 01/01/2013 – 12/31/2013

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family | Plan Type: CDHP

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition	Generic drugs	\$10 copay/ retail \$20 copay/mail	Not covered	Retail is limited to a 30 day supply Mail order is limited to a 90 day supply Benefit applies deductible and accumulates to out of pocket maximum.
	Preferred brand drugs	20%/ retail min \$30, max \$50 20%/ mail min \$60, max \$100	Not covered	Retail is limited to a 30 day supply Mail order is limited to a 90 day supply Benefit applies deductible and accumulates to out of pocket maximum.
	Non-preferred brand drugs	40%/ retail min \$50, max \$70 20%/ mail min \$100, max \$140	Not covered	Retail is limited to a 30 day supply Mail order is limited to a 90 day supply Benefit applies deductible and accumulates to out of pocket maximum.
	Specialty drugs	40% min \$75, max \$150	Not covered	Retail and mail order prescription are limited 30-days supply. Benefit applies deductible and accumulates to out of pocket maximum.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	_____none_____
	Physician/surgeon fees	20% coinsurance	40% coinsurance	_____none_____

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Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	—————none—————
	Emergency medical transportation	20% coinsurance	20% coinsurance	—————none—————
	Urgent care	20% coinsurance	20% coinsurance	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	—————none—————
	Physician/surgeon fee	20% coinsurance	40% coinsurance	—————none—————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	40% coinsurance	—————none—————
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Substance use disorder outpatient services	20% coinsurance	40% coinsurance	—————none—————
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	—————none—————
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	—————none—————

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If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	\$5,000 lifetime maximum for private duty nursing. No registered nurse and licensed practical nurse unless billed through a home health care agency.
	Rehabilitation services	20% coinsurance	40% coinsurance	Physical, occupational, and speech therapy are limited to 25 visits each. Manipulation therapy is limited to 12 visits.
	Habilitation services	20% coinsurance	40% coinsurance	All rehabilitation and habilitation visits count toward your rehabilitation visit limit.
	Skilled nursing care	Not covered	Not covered	Skilled nursing is not covered unless approved through case management as alternative to inpatient higher cost care.
	Durable medical equipment	20% coinsurance	40% coinsurance	—————none—————
	Hospice service	20% coinsurance	20% coinsurance	—————none—————
If your child needs dental or eye care	Eye exam	No charge	40% coinsurance	Not subject to deductible. Typically this type of exam is performed at your physician's office and only routine vision screening is covered
	Glasses	Not covered	Not covered	—————none—————
	Dental check-up	Not covered	Not covered	—————none—————

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn’t a complete list. Check your policy or plan document for other excluded services.)

- | | | |
|-----------------------|-------------------------|--|
| • Acupuncture | • Hearing aids | • Non-emergency care when traveling outside the U.S. |
| • Cosmetic surgery | • Infertility treatment | • Routine foot care |
| • Dental care (Adult) | • Long-term care | • Weight loss programs |

Other Covered Services (This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- | | | |
|---------------------|--|----------------------------|
| • Bariatric surgery | • Most coverage provided outside the United States. | • Private-duty nursing |
| • Chiropractic care | See www.BCBS.com/bluecardworldwide | • Routine eye care (Adult) |

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-877-814-9709. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact:

Medical:

Anthem Appeals

P.O. Box 33200

Louisville, KY 40232-3200

Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoolwoł íínízinigo t'áá diné k'éjígó, t'áá shoodí ba na'alníhí ya sidáhi bich'í naabídííłkiid. Eí doo biigha daago ni ba'nija'go ho'aalagíí bich'í hodiilní. Hai'daa iini'taago eíya, t'áá shoodí diné ya atáh halne'ígú ní béesh bee hane'í wólta' bi'ki si'niilígú bi'kéhgo bich'í hodiilní.

—————To see examples of how this plan might cover costs for a sample medical situation, see the next page.—————

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is
not a cost
estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$4,040
- Patient pays \$3,500

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$2,500
Copays	\$0
Coinsurance	\$1,000
Limits or exclusions	\$0
Total	\$3,500

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$2,340
- Patient pays \$3,060

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$2,500
Copays	\$0
Coinsurance	\$560
Limits or exclusions	\$0
Total	\$3,060

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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